STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

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F000000	This visit was for the Investigation of Complaints IN00129700 and IN00130084. Complaint IN00129700-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, and F323. Complaint IN00130084-Substantiated. Federal/state deficiencies related to the allegations are cited at F166, F282 and F465. Survey dates: June 10 and 11, 2013 Facility number: 000476 Provider number:155446 AIM number: 100290870 Survey team: Christine Fodrea, RN TC Census bed type: SNF/NF: 136	F000000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 136 Census payor type: Medicare: 27 Medicaid: 78 Other: 31 Total: 136 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 14, 2013 by Randy Fry RN.			

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F000166 SS=F	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, interview and record review the facility failed to promptly resolve call light concerns. This had the potential to affect all 136 residents residing in the facility. Findings include: During an observation on 6-10-2013 between 3:49 PM and 4:13 PM, the call light in room 303 was sounding without being responded to. In a confidential interview on 6-10-2013 at 4:20 PM, a resident indicated they had to wait more than 5 minutes for the call light to be answered that afternoon. During an observation on 6-11-2013 between 8:38 AM and 8:52 AM, the call light in room 101 was sounding without being responded to. In a confidential interview on 6-11-2013 at 10:00 AM, a resident indicated they had to wait longer than 5 minutes for the call light to be answered that morning.	F000166	Resident Council meeting to identify any concerns with call light response time. Staff re-educated on answering call lights in a timely manner. Guardian Angels will monitor call light response time 5x/week on random shifts. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistent pattern of compliance with a subsequent plan developed and implemented as necessary.	07/12/2013

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	In an interivew on 6-10-2013 at 2:35 PM, LPN #2 indicated call lights were to be responded to within 5 minutes. A review of resident council minutes, dated 1-24-2013, indicated call lights were answered, but the resident needs were not being cared for. A response to the resident council concern indicated staff had been reeducated to leave the light on until the resident need was addressed. In the minutes dated 4-24-2013, the minutes indicated there was not enough staff to help answer call lights on weekends. There was no response on the minutes to this concern. In the minutes dated 5-22-2013, the minutes indicated call lights were not being answered in a timely manner. There was no response in the minutes to this concern. This Federal tag relates to Complaint IN00130084. 3.1-7(a)(2)			

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F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review the facility failed to follow physician orders for 2 of 4 residents with physician orders for wanderguard checks (Resident #C and Resident #G), and 2 of 3 residents for following physician orders regarding medication administration in a sample of 7 (Resident #A and Resident #F) Findings include: 1. Resident #G's record was reviewed 6-11-2013 at 10:51 AM. Resident #G's diagnoses included, but were not limited to stasis ulcer, cellulitis, and diabetes. A physician's order dated 5-29-2013 indicated to place a wanderguard bracelet on Resident #G and to check placement every shift. A review of Resident #G's Treatment Record (TAR) dated 6-2013 indicated no area had been designated for the nurse's to document wanderguard placement.	F000282	The facility will follow physician orders for treatments and medications will be administered by qualified personnel. Resident C & G TAR's were updated to include monitoring of wander guard every shift during the survey. Residents A & F were assessed and no negative outcome noted. Facility completed a one-time audit of medication availability. Facility also audited all residents with wander guards to ensure monitoring on the TAR and updated as needed. Licensed staff re-educated on medication administration and what to do if a medication is not available. Licensed staff re-educated to include wander guard checks on the TAR for monitoring every shift. UM/designee will monitor MAR/TAR's 5x/week for 4 weeks and then 2/x weekly going forward for compliance related to wander guard checks and medication availability. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistent pattern of compliance with a subsequent plan developed and implemented as necessary.	07/12/2013

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	In an interview on 6-11-2013 at 11:01 AM, LPN #6 indicated placement of the wanderguard had not been checked because there was no reminder on the TAR. In an interview on 6-11-2013 at 11:23 AM, RN #5 indicated the wanderguard placement and function checks should have been on the TAR and was unsure why they were not. 2. Resident #C's record was reviewed 6-11-2013 at 9:30 AM. Resident #C's diagnoses included, but were not limited to dementia, dizziness, and high blood pressure. Resident #C's physician order summary dated 6-2013 indicated the facility was to check placement of Resident #C's wanderguard every shift. A review of Resident #C's TAR dated 6-2013 indicated no initials in the areas for 6-3, 6-4, and 6-5 on the 7-3 and 3-11 shifts; no initials for any shift on 6-6 and 6-7; and no initial on 6-8 for the night shift. In an interview on 6-11-2013 at 10:02 AM, LPN #4 indicated the wanderguard placement should have been checked, but if the boxes were			

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	not initialed, it probably wasn't done. 3. Resident #A's record was reviewed 6-11-2013 at 1:45 PM. Resident #A's diagnoses included but were not limited to breast cancer with metastasis to the brain, diabetes, and GERD. Physician's orders dated 5-17-2013 at 6 PM indicated Resident #A was to receive Lantus insulin 22 units at 9 PM. A review of Resident #A's Medication Administration Record (MAR) indicated there was no documentation Resident #A received the ordered Lantus insulin on 5-17-2013. In an interview on 6-11-2013 at 3:37 PM, LPN #3 indicated Resident #A should have received her 9 PM insulin on 5-17-2013, even though there was none availabe in the medication cart, because medication was available in the Emergency Drug Kit (EDK). A review of the EDK log indicated no insulin had been obtained for Resident #A on 5-17-2013. A review of Resident #A's blood sugars the morning of 5-18-2013 indicated her blood sugar was 124.			

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	4. Resident #F's record was reviewed 6-11-2013 at 3:28 PM. Resident #F's diagnoses included, but were not limited to, seizure disorder, lung disease, and stroke. A review of Resident #F's physician order summary dated 6-2013 indicated Resident #F was to receive Ventolin inhaler 90 micrograms 2 puffs orally 4 times per day. A review of Resident #F's MAR dated 6-2013 indicated resident #F had not received his Ventolin inhaler on 6-8, 6-9, and 6-10. The MAR indicated the scheduled doses had been circled as not given. There was no explanation on the back of the MAR as to why the medication had not been given. A review of Resident #F's nurse's notes dated 6-8, 9, and 10-2013 did not indicate why the medication had not been given. In an interview on 6-10-2013 at 11:14 AM, Resident #A indicated he had not received his inhaler since 6-8-2013 and he was beginning to get short of breath. In an interview on 6-11-2013, LPN #4 indicated she was insure why			

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	Resident #A's Ventolin was unavailable on 6-8, 6-9, and 6-10. She further indicated it had been ordered for the pharmacy on 6-10 when she discovered the medication was not available and it had been received in time for the morning dose on 6-11-2013. This Federal tag relates to Complaint IN00129700 and IN00130084. 3.1-35(g)(2)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to assess risk for and implement interventions to prevent elopement for 2 of 3 residents reviewed for elopement preventions in a sample of 7. (Resident #B and Resident #G) Findings include: 1. Resident #G's record was reviewed 6-11-2013 at 10:51 AM. Resident #G's diagnoses included, but were not limited to stasis ulcer, cellulitis, and diabetes. Nurse's notes dated 5-29-2013 at 10:30 AM, indicated Resident #G had been seen by the Administrator exiting the building and was in the parking lot headed for the road. The note further indicated Resident #G was showing signs of increased confusion. A physician's order dated 5-29-2013 indicated to place a wanderguard bracelet on Resident #G and to check	F000323	Resident #B & G's elopement assessment updated along with the TAR during the survey. The facility reviewed all resident's at risk for elopement assessment and updated as needed. Licensed staff and Social Services were re-educated on completing elopement assessments when moving off the secure unit. Licensed staff re-educated to include wander guard checks on the TAR for monitoring every shift. Social Service/designee will monitor elopement risk assessments are completed appropriately. IDT/designee will monitor compliance with elopement assessment completion thru routine walking rounds. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistent pattern of compliance with a subsequent plan developed and implemented as necessary.	07/12/2013

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	placement every shift. A review of Resident #G's Treatment Record (TAR) dated 6-2013 indicated no area had been designated for the nurse's to document wanderguard placement. Nurse's notes dated 6-10-2013 indicated Resident #G had gotten out of the building with his wanderguard intact and was sitting in the employee smoking area. During an observation on 6-11-2013 at 11:17 AM, Resident #G approached a door that had a wanderguard alert and the alarm did not sound, nor did the door lock. In an interview on 6-11-2013 at 12:10 PM, RN #5 indicated the alarm had not sounded a few days ago, but had been functional since that time. In an interview on 6-11-2013 at 11:01 AM, LPN #4 indicated placement of the wanderguard had not been checked because there was no reminder on the TAR. On 6-11-2013 at 12:30 PM, the facility immediately changed the wanderguard bracelet for Resident #G and double checked all the doors			

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	to assure the bracelets were sensing at the doors. 2. Resident #B's record was reviewed 6-10-2013 at 4:00 PM. Resident #B's diagnoses included but were not limited to closed brain injury, and traumatic fractures. Nurse's notes dated 5-9-2013 at 8:30 PM indicated Resident #B was placed on a locked unit due to combative behavior. An elopement assessment dated 5-9-2013 had been completed showing Resident #B was at risk for elopement, but not high risk. Nurse's notes dated 5-15-2013 at 9:40 AM indicated Resident #B had been taken off the locked unit and placed on an open floor because he had been cooperative and was no longer combative. There was no elopement assessment completed after the move. On 5-25-2013 at 9:05 AM, the nurse's notes indicated Resident #B was observed across the street by two CNAs who promptly returned him to the facility. A wanderguard was placed and a new elopement			

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	assessment was completed. The elopement assessment dated 5-25-2013 showed Resident #B to be at high risk for elopement. In an interview on 6-10-2013 at 4:38 PM, SSD #7 indicated Resident #B was not reassessed for elopement risk after moving off a locked unit because nursing didn't think it was necessary. A current policy titled Elopement and missing resident policy dated October 2009 provided by the Administrator on 6-10-2013 at 10:26 AM indicated assessment guidelines included but were not limited to initial assessment, changes in cognition, and Interdiscipinary Team (IDT) walking rounds reviews. This Federal tag relates to Complaint IN00129700. 3.1-45(a)(2)			

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain carpeting free from stains in 4 of 13 carpeted rooms. This had the potential to affect 4 residents residing in the facility. Findings include: During an environmental tour on 6-10-2013 at 1:40 PM, a darkened area of carpeting was observed in room 310 in the middle of the room. The area was approximately 10 inches in diameter. During an environmental tour on 6-10-2013 at 1:43 PM in room 311, in the middle of the room, a darkened area of carpeting was observed approximately 15 inches by 4 inches. During an environmental tour 6-10-2013 at 1:51 PM a darkened area was observed on the carpet by the bathroom, in room 503. The area was approximately 10 inches x 10 inches. During an environmental tour	F000465	The facility will ensure that its carpet cleaning schedules are adhered to. All carpets were cleaned in the facility on 6/10/13 and will be monitored by the Maintenance Supervisor/designee weekly going forward. Executive Director will review logs on a monthly basis to ensure carpets are being cleaned. Carpet cleaning schedule developed and implemented during the survey. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistent pattern of compliance with a subsequent plan developed and implemented as necessary.	07/12/2013

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	6-10-2013 at 1:59 PM, a darkened area of carpeting was observed in the middle of the room approximately 5 inches x 10 inches. In an interview on 6-10-2013 the Maintenance Director indicated the carpet cleaner had not been working, and so, the schedule to clean the carpets had not been able to be completed. He furhter indicated the carpets were to be cleaned at least quarterly, but he was unsure the last time the carpets had been cleaned. In an interview on 6-10-2013 at 2:32 PM, Floor Tech #1 indicated the facility had only one sweeper and had no carpet shampooer at all the last several months. He further indicated the facility just cleaned the carpets as it was needed, and there was no current carpet cleaning schedule. A current carpet cleaning log provided by the Administrator on 6-11-2013 at 9:10 AM indicated to "clean all the carpeted rooms the third week of every quarter". This Federal tag relates to Complaint IN00130084. 3.1-19(f)			

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